



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

SPINECARE, LLP
5734 SPOHN DRIVE
CORPUS CHRISTI TX 78414

Respondent Name

STATE OFFICE OF RISK MANAGEMENT

Carrier's Austin Representative Box

Box Number 45

MFDR Tracking Number

M4-11-4455-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary dated August 1, 2011: "Authorization was obtained prior to services being rendered. This patient was approved for left knee steroid injection X3. Please see exhibit # 10, which is the authorization for the services. Carrier failed to pay this claim at the correct MAR. Therefore, this claim is being sent to TDI for determination. MAR was calculated using the Medicare allowed amount and multiplying that by 235%."

Requestor's Supplemental Position Summary dated January 26, 2012: "For each of these dates of service the MAR is \$100.16, as noted on my appeals to the carrier and on the MFDR. These dates of service are still open due to the fact that the carrier has failed to pay these claims at the MAR rate. Below is a breakdown of the payments received for each date of service and their corresponding balance."

Amount in Dispute: \$8.61

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "In review of the dispute packet submitted by the requestor...the Office performed an in-depth review of dates of service 4/8/2011- 4/22/2011 and determined that additional reimbursement is warranted for dates of service 4/15/2011 and 4/22/2011. The original reimbursement for date of service 4/8/2011 is correct pursuant to the Division's medical fee guidelines and payment policies." "CPT code 20610 has a payment indicator of P3 which is defined as Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs. The calculation methodology used for CPT code 20610 is base rate is \$48.28/WI 33.9764 X Conversion factor \$68.47 = \$97.29."

Response Submitted by: SORM, P.O. Box 13777, Austin, TX 78711

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
April 8, 2011 April 15, 2011 April 21, 2011	ASC Services for Code 20610-SG-LT	\$2.87/day X 3 = \$8.61	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §134.402, titled *Ambulatory Surgical Center Fee Guideline*, effective August 31, 2008, sets out the reimbursement guidelines for ambulatory surgical care services.
3. 28 Texas Administrative Code §134.203, titled *Medical Fee Guideline for Professional Services*, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

Explanation of benefits dated May 4, 2011, May 17, 2011

- W1-Workers Compensation state fee schedule adjustment.

Explanation of benefits dated June 3, 2011

- W1-Workers Compensation state fee schedule adjustment.
- 193-Original payment decision is being maintained. This claim was processed properly the first time.
- ASC P3 status indicator code is allowed accordly to the MPFS nonfacility PE RVUs per Division rule at 28 TAC 134.402(h).

Explanation of benefits dated June 14, 2011 and June 15, 2011

- W1-Workers Compensation state fee schedule adjustment.
- 193-Original payment decision is being maintained. This claim was processed properly the first time.

Explanation of benefits dated August 12, 2011, 2009

- W1-Workers compensation state fee schedule adjustment.
- W3-Additional payment made on appeal/reconsideration.

Issues

1. What is the payment indicator for HCPCS code 20610?
2. Did the requestor support position that additional reimbursement is due for ASC services for code 20610? Is the requestor entitled to reimbursement?

Findings

1. According to the explanation of benefits, the carrier paid the services based upon ASC payment indicator code "P3".

A review of Medicare's Addendum AA reveals that HCPCS code 20610 has a payment indicator of P3.

According to Medicare's Addendum DD1, ASC payment indicator P3 is defined as "Office-based surgical procedure added to ASC list in CY 2008 or later with MPFS nonfacility PE RVUs; payment based on MPFS nonfacility PE RVUs."

Therefore, HCPCS code 20610 has a payment indicator of P3.

2. 28 Texas Administrative Code §134.402(d) states " For coding, billing, and reporting, of facility services covered in this rule, Texas workers' compensation system participants shall apply the Medicare payment policies in effect on the date a service is provided with any additions or exceptions specified in this section."

28 Texas Administrative Code §134.402(f)(1)(A) states "The reimbursement calculation used for establishing the MAR shall be the Medicare ASC reimbursement amount determined by applying the most recently adopted and effective Medicare Payment System Policies for Services Furnished in Ambulatory Surgical Centers and Outpatient Prospective Payment System reimbursement formula and factors as published annually in the *Federal Register*. Reimbursement shall be based on the fully implemented payment amount as in ADDENDUM AA, ASC COVERED SURGICAL PROCEDURES FOR CY 2008, published in the November 27, 2007 publication of the *Federal Register*, or its successor. The following minimal modifications apply: (1) Reimbursement for non-device intensive procedures shall be: (A) The Medicare ASC facility reimbursement amount multiplied by 235 percent."

28 Texas Administrative Code §134.402(h) states "For medical services provided in an ASC, but not addressed in the Medicare payment policies as outlined in subsection (f) of this section, and for which Medicare reimburses using other Medicare fee schedules, reimbursement shall be made using the applicable Division Fee Guideline in effect for that service on the date the service was provided."

HCPCS code 20610 is described as “Arthrocentesis, aspiration and/or injection; major joint or bursa (eg, shoulder, hip, knee joint, subacromial bursa).”

The Division finds that Medicare reimburses this service using the Medicare Professional Fee Schedule for nonfacility practice expenses. Therefore, per Division rule at 28 TAC §134.402(h), reimbursement for this service shall be made using the Division fee guideline applicable to nonfacility professional services.

Per 28 Texas Administrative Code §134.203, the MAR for CPT code 20610 rendered in Corpus Christi, TX on the disputed date of service is \$97.29. The insurance carrier paid \$97.29 for each disputed date of service. The difference between the amount due and the amount paid is \$0.00. As a result, the amount recommended for additional reimbursement is \$0.00.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, the Division concludes that the requestor has not supported its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

_____	_____	2/9/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.